



July 21, 2025

Submitted Electronically via Regulations.gov Portal

Dockets Management Staff
Department of Health and Human Services
Food and Drug Administration
5630 Fishers Lane, Rm. 1061
Rockville, MD 20852

Re: Citizen Petition from American College of Obstetricians and Gynecologists (FDA-2025-P-0377)

Dear Dockets Management Staff:

On behalf of Americans United for Life (“AUL”), we are writing in response to the citizen petition filed by the American College of Obstetricians and Gynecologists (“ACOG”), FDA-2025-P-0377. AUL is the oldest pro-life, nonprofit legal advocacy organization in the country. Founded in 1971, before the Supreme Court’s decision in *Roe v. Wade*,¹ AUL has dedicated over fifty years to advocating for comprehensive legal protections for human life from conception until natural death. AUL attorneys are legal experts on statutory interpretation and bioethics, and regularly testify before state legislatures and Congress on abortion issues.² Supreme Court opinions have cited AUL briefs and scholarship in major bioethics cases, including *Dobbs v. Jackson Women’s Health Organization*.³ One of the authors of this comment has published scholarship on the Comstock Act’s mail-order abortion rules, 18 U.S.C. §§ 1461–1462, which prohibit mailing or shipping abortifacient matter.⁴

Thank you for the opportunity to comment on ACOG’s citizen petition, which is requesting the U.S. Food and Drug Administration (“FDA”) to remove the mifepristone Risk Evaluation and Mitigation Strategy (“REMS”), including its Elements to Assure Safe Use (“ETASU”), or, alternatively, to refrain from creating

¹ 410 U.S. 113 (1973), *overruled by* *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215 (2022).

² See, e.g., *What’s Next: The Threat to Individual Freedoms in a Post-Roe World Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life).

³ 597 U.S. at 271 (citing CLARKE D. FORSYTHE, ABUSE OF DISCRETION: THE INSIDE STORY OF ROE V. WADE 127, 141 (2012)).

⁴ Carolyn McDonnell, *Mail-Order Abortion Rules: Text, Context, and History of the Comstock Act’s Restrictions on Mailing Abortifacient Matter*, 23 AVE MARIA L. REV. 101 (2025).

new safeguards or reestablishing prior safeguards to promote patient safety.⁵ Below, we discuss (I) the background of the FDA’s approval and deregulation of chemical abortion drugs, and urge you to deny ACOG’s citizen petition because (II) current ETASU safeguard the health and informed consent of patients; (III) the 2021 non-enforcement decision and 2023 removal of the in-person dispensing requirement are not in accordance with federal law’s restrictions on mailing or shipping abortifacient matter; (IV) the FDA should reestablish prior safeguards mandating adverse event reporting and requiring in-person dispensing; and (V) the FDA should implement an ultrasound safeguard to confirm the gestational age and rule out ectopic pregnancy prior to a mifepristone prescription. Accordingly, we urge the FDA to strengthen, not remove, protections for patients seeking a chemical abortion.

I. Background of the FDA’s Approval and Deregulation of Mifepristone.

The “chemical abortion pill” (also known as a “medical abortion”) is a regimen of two drugs, mifepristone and misoprostol.⁶ “[M]ifepristone (brand name, Mifeprex), is an antiprogesterone, which starves the pregnancy. The second, misoprostol (brand name, Cytotec), a prostaglandin, causes the uterus to contract, which mechanically expels the fetus and placenta.”⁷ Women commonly experience cramping, bleeding, nausea, weakness, vomiting, headache, and dizziness from the drugs.⁸ During a chemical abortion, “[t]he average woman bleeds for 9–16 days and eight percent will bleed longer than a month.”⁹ Complications increase exponentially as the pregnancy progresses.¹⁰ In some cases, the chemical abortion may fail to end the pregnancy or fail to expel the deceased fetus, creating a need for surgical intervention.¹¹ Woman also may experience hemorrhaging or infection due to retained fetal remains.¹²

In 2000, the FDA approved Population Council’s new drug application for chemical abortion drugs to terminate a pregnancy up to seven weeks gestation.¹³ The FDA included a black box warning on the drug label about “serious and sometimes

⁵ American College of Obstetricians and Gynecologists Citizen Petition at 1, FDA-2025-P-0377 (Jan. 31, 2025).

⁶ *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, U.S. FOOD & DRUG ADMIN. (Feb. 11, 2025), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation>.

⁷ Clarke D. Forsythe & Donna Harrison, *State Regulation of Chemical Abortion After Dobbs*, 16 LIBERTY U. L. REV. 377, 377 (2022).

⁸ RSCH. COMM., AM. ASS’N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, MEDICATION ABORTION, PRAC. GUIDELINE NO. 8, at 3 (2020).

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 375 (2024).

fatal infections or bleeding.”¹⁴ To protect patients, “only doctors could prescribe or supervise prescription of Mifeprex,” “[d]octors and patients also had to follow a strict regimen requiring the patient to appear for three in-person visits with the doctor,” and doctors had to report serious adverse events.¹⁵ However, the approval did not contain an ultrasound requirement, even though the Population Council had relied on three clinical studies which used the condition of “an ultrasound to verify gestational age and diagnose ectopic pregnancies.”¹⁶

The FDA used its “accelerated approval” process under 21 C.F.R. § 314 subpart H to approve chemical abortion drugs.¹⁷ When Congress enacted the REMS framework in 2007, it determined existing drugs approved under Subpart H, including chemical abortion drugs, had an approved REMS in effect.¹⁸

Subpart H applies to drugs for “treating serious or life-threatening illnesses” which “provide meaningful therapeutic benefit to patients over existing treatments.”¹⁹ The FDA “consider[s] accelerated approval in two situations: where the agency can reliably estimate effectiveness using a ‘surrogate endpoint’; and where FDA ‘determines that a drug, effective to the treatment of a disease, can be used safely only if distribution or use is modified or restricted.’”²⁰ Here, the FDA used its Subpart H authority, reasoning that “the termination of an unwanted pregnancy is a serious condition within the scope of Subpart H. The meaningful therapeutic benefit over existing surgical abortion is the avoidance of a surgical procedure.”²¹ Likewise, the FDA determined Subpart H was appropriate because chemical abortion drugs “could not be administered safely without imposing certain use restrictions.”²²

The FDA exceeded its legal authority by approving mifepristone under its Subpart H authority. As the U.S. House Committee on Government Reform (now known as the Committee on Oversight and Accountability)’s Subcommittee on Criminal Justice, Drug Policy and Human Resources recognized, “the term ‘serious

¹⁴ *Mifeprex Prescribing Information*, U.S. FOOD & DRUG ADMIN. 1, 1 (Jan. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/020687Orig1s025Lbl.pdf (capitalization omitted).

¹⁵ *FDA*, 602 U.S. at 375.

¹⁶ *All. for Hippocratic Med. v. Food & Drug Admin.*, 78 F.4th 210, 224 (5th Cir. 2023), *rev’d on other grounds*, 602 U.S. 367.

¹⁷ *Id.* at 223–24.

¹⁸ 21 U.S.C. 331 note.

¹⁹ 21 C.F.R. § 314.500 (2024).

²⁰ *All. for Hippocratic Med.*, 78 F.4th at 223 (citing New Drug, Antibiotic, and Biological Drug Product Regulations; Accelerated Approval, 57 Fed. Reg. 58,942, 58,942 (Dec. 11, 1992)).

²¹ 2000 FDA Approval Memo. to Population Council re: NDA 20-687 Mifeprex (mifepristone) at 6 (Sept. 28, 2000), *quoted in All. for Hippocratic Med.*, 78 F.4th at 224.

²² *All. for Hippocratic Med.*, 78 F.4th at 224 (citing 2000 FDA Approval Memo., *supra* note 21, at 6).

condition’ is not found in the Subpart H rule.”²³ Likewise, “[t]here are situations in which pregnancies become serious or life-threatening, but the underlying condition is not ‘serious or life-threatening.’ Moreover, pregnancy itself is not an illness. There are situations in which serious or life-threatening complications may arise, but these are atypical events.”²⁴

The FDA indicated chemical abortion drugs provided a “meaningful therapeutic benefit over existing surgical abortion” by “avoid[ing] a surgical procedure.”²⁵ This circular reasoning belied the fact that chemical abortion drugs were “not approved for a medical indication intended for only the treatment of patients who were intolerant of surgical abortion. It was approved to treat the general population of women seeking first-trimester abortions.”²⁶ Similarly, women taking chemical abortion drugs had to tolerate surgery because “surgical intervention may be needed” to treat “incomplete abortion or other complications.”²⁷

There were other issues with the approval of chemical abortion drugs. The drug regimen was also “highly unusual.”²⁸ “The use of misoprostol was not only an unapproved or off-label use—it was actually contraindicated at that time.”²⁹ At the time of approval, the FDA also had no evidence of the drugs’ psychological or long-term physical effects.³⁰

²³ STAFF OF SUBCOMM. ON CRIM. JUST., DRUG POL’Y & HUM. RES. OF THE H. COMM. ON GOV’T REFORM, 109TH CONG., THE FDA AND RU-486: LOWERING THE STANDARD FOR WOMEN’S HEALTH 20 (Subcomm. Print 2006).

²⁴ *Id.*

²⁵ 2000 FDA Approval Memo., *supra* note 21, at 6 (Sept. 28, 2000), *quoted in* STAFF OF SUBCOMM. ON CRIM. JUST., *supra* note 23, at 21.

²⁶ STAFF OF SUBCOMM. ON CRIM. JUST., *supra* note 23, at 22.

²⁷ *Mifeprax Prescribing Information*, *supra* note 14, at 1.

²⁸ STAFF OF SUBCOMM. ON CRIM. JUST., *supra* note 23, at 23.

²⁹ *Id.*

³⁰ FDA Commissioner Jane Henney testified before Congress in February 2000 regarding the FDA’s review of chemical abortion drugs:

The primary clinical trials conducted by the sponsor to support the safety and efficacy of mifepristone—RU-486—were discussed before the Reproductive Health Advisory Committee in July 1996. *These clinical studies did not include an evaluation of the psychological effects of the drug in women or an evaluation of the long-term medical consequences of the drug in women.* FDA is unaware of any published studies on the psychological effects or the long-term medical consequences of mifepristone in women.

Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations for 2001: Part 2 of Hearings Before the Subcomm. of the Comm. on Appropriations, 106th Cong. (2000), available at <https://www.govinfo.gov/content/pkg/CHRG-106hhrg63888/html/CHRG-106hhrg63888.htm> (emphasis added).

The approval of mifepristone posed particular safety issues for adolescents. The FDA waived the pediatric rule,³¹ which was in effect as an administrative rule at the time of mifepristone's approval but is now codified as the Pediatric Research Equity Act ("PREA").³² PREA requires new drug applications to assess the safety, effectiveness, dosing, and administration for pediatric patients.³³ PREA retroactively considered "a waiver or deferral of pediatric assessments" under the pediatric rule between April 1, 1999 and December 3, 2003 to be a waiver or deferral under PREA,³⁴ which included the waiver of pediatric assessments for the FDA's approval of mifepristone in 2000. According to the FDA, "there is no biological reason to expect menstruating females under age 18 to have a different physiological outcome with the regimen."³⁵ This contention was unsupported, and contradicted by how adolescents do not have fully developed decision-making capabilities compared to adults,³⁶ have a "biological predisposition for high-risk pregnancies,"³⁷ and often delay care.³⁸ Likewise, the FDA did not know how mifepristone, an anti-progestin which interferes with the immune system, affects adolescent development.³⁹

In 2016, the FDA approved Danco Laboratories' (the distributor of Mifeprex) supplemental new drug application that sought to remove certain safeguards.⁴⁰ The FDA increased the indicated use from seven to ten weeks gestation, permitted non-physician healthcare providers (such as nurse practitioners) to prescribe chemical

³¹ 21 C.F.R. § 314.55(c) (2024). A federal district court enjoined the FDA from enforcing the pediatric rule in 2002, holding the FDA exceeded its statutory authority by promulgating the pediatric rule. *See Ass'n of Am. Physicians & Surgeons v. FDA*, 226 F. Supp. 2d 204 (D.D.C. 2002). However, Congress subsequently codified the pediatric rule and incorporated certain previous waivers or deferrals under the pediatric rule, which includes the waiver of the pediatric rule during the approval of mifepristone. *See infra* notes 32–34 and accompanying text.

³² 21 U.S.C. § 355c.

³³ *Id.* § 355c(a)(2)(A).

³⁴ *Id.* § 355c note.

³⁵ 2000 FDA Approval Memo., *supra* note 21, at 7, *quoted in* Compl. ¶ 153, *All. for Hippocratic Med. v. FDA*, 668 F. Supp. 3d 507 (N.D. Tex. 2023) (No. 2:22-cv-223-Z), *vacated in part*, 78 F.4th 210, *rev'd on other grounds*, 602 U.S. 367.

³⁶ *H.L. v. Matheson*, 450 U.S. 398, 411 (1981), *abrogated by Dobbs*, 597 U.S. 215; Aviva L. Katz et al., *Informed Consent in Decision-Making in Pediatric Practice*, PEDIATRICS, Jan. 2023, at e1, e2 ("A reliance on individual liberties and autonomy in the pediatric patient is not realistic or legally accepted, so parents or other surrogates provide 'informed permission' for diagnosis and treatment, with the assent of the child as developmentally appropriate.").

³⁷ Nadia Akseer et al., *Characteristics and Birth Outcomes of Pregnant Adolescents Compared to Older Women: An Analysis of Individual Level Data from 140,000 Mothers from 20 RCTs*, ECLINICALMED., Feb. 26, 2022, at 1, 3.

³⁸ Nathalie Fleming et al., *Adolescent Pregnancy Guidelines*, 37 J. OBSTETRICS & GYNAECOLOGY CAN. 740, 743 (2015).

³⁹ *See* STAFF OF SUBCOMM. ON CRIM. JUST., *supra* note 23, at 12–13 (recognizing medical concerns about mifepristone's immune system inhibition); *see also* Compl., *supra* note 35, at ¶ 216 ("The FDA did not require any studies on the long-term effects of chemical abortion drugs in pediatric populations with developing reproductive systems.").

⁴⁰ *FDA*, 602 U.S. at 375.

abortion drugs, “reduced the number of required in-person visits from three to one—a single visit to receive Mifeprex,” and altered adverse event reporting requirements so that prescribers only had to report fatalities.⁴¹ The FDA also “[s]witch[ed] the method of administration for misoprostol from oral to buccal” and “[c]hang[ed] the dose of mifepristone (600 mg to 200 mg) and misoprostol (400 mcg to 800 mcg).”⁴²

These changes exceeded the FDA’s legal authority and presented significant patient safety issues. The action was arbitrary and capricious because the “FDA did not consider the cumulative effect of the 2016 Amendments” and even “admit[ted] that none of the studies it relied on examined the effect of implementing all of those changes together. It studied the amendments individually.”⁴³ The removal of the physician-only rule posed safety issues because non-physicians have less training in handling medical complications.⁴⁴ Increasing the indicated use from seven to ten weeks gestation also presented a safety concern because “[t]he rate of . . . complications increase exponentially as gestational age increases.”⁴⁵ Finally, the FDA could not effectively monitor adverse events following the 2016 changes because it only required adverse event reporting for fatalities, which we discuss below in Section IV(A).

In 2019, the “FDA approved an application for generic mifepristone. [The] FDA established the same conditions of use for generic mifepristone as for Mifeprex.”⁴⁶ In this regard, the approval of the generic mifepristone carried the same legal and patient safety issues that arose for Mifeprex because of the 2016 deregulation.

In 2021, during the COVID-19 pandemic, the FDA decided to not enforce the in-person dispensing requirement.⁴⁷ “Effectively, this allowed mifepristone to be prescribed remotely and sent via mail.”⁴⁸ As discussed below in Sections III and IV(B), this action was in tension with federal law’s prohibition on mailing or shipping abortifacient matter, and raised informed consent concerns by increasing the risk of intimate partner violence.⁴⁹

⁴¹ *Id.* at 375–76.

⁴² *All. for Hippocratic Med.*, 78 F.4th at 226.

⁴³ *Id.* at 246.

⁴⁴ RSCH. COMM., AM. ASS’N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, STATE RESTRICTIONS ON ABORTION: EVIDENCE-BASED GUIDANCE FOR POLICYMAKERS, COMM. OP. NO. 10 at 10–12 (2022).

⁴⁵ RSCH. COMM., AM. ASS’N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, MEDICATION ABORTION, *supra* note 8, at 3.

⁴⁶ *FDA*, 602 U.S. at 376.

⁴⁷ *Id.*

⁴⁸ *All. for Hippocratic Med.*, 78 F.4th at 226.

⁴⁹ See generally Megan Hall et al., *Associations Between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis*, PLOS MED., Jan. 7, 2014, at 1; COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, INTIMATE PARTNER VIOLENCE, COMM. OP. NO. 518 (reaffirmed 2025).

In 2023, the FDA formalized the removal of the in-person dispensing requirement.⁵⁰ Like the 2021 action, the 2023 action conflicted with federal law that restricted mailing or shipping abortifacient matter, as well as presented informed consent issues. In 2023, the FDA also added a pharmacy certification requirement, which permitted retail pharmacies to dispense mifepristone if the pharmacy “meets the requirements of the Mifepristone REMS Program.”⁵¹

The ACOG citizen petition is now asking the FDA to remove the mifepristone REMS, including its ETASU, to further eliminate safeguards for patients. Alternatively, the ACOG citizen petition asks the FDA to not reinstate prior safeguards or implement new safeguards to protect patient health and safety. We urge the FDA to deny ACOG’s citizen petition.

II. Current ETASU Safeguard the Health and Informed Consent of Patients.

The FDA should retain current ETASU that “assure safe use of the drug” by ensuring informed consent and protecting the safety of patients.⁵² These ETASU include: the (A) prescriber certification, (B) pharmacy certification, and (C) patient agreement form.

A. *The Prescriber Certification ETASU Protects the Health and Safety of Patients.*

The prescriber certification ETASU ensures patients receive prompt medical care if they suffer complications. Under this ETASU, prescribers verify that they have the:

Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and be able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.⁵³

As mifepristone’s black box warning details, “[p]rolonged heavy bleeding may be a sign of incomplete abortion or other complications and prompt medical or surgical intervention may be needed.”⁵⁴

⁵⁰ *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, *supra* note 6.

⁵¹ *Id.*

⁵² See 21 U.S.C. 355-1(f)(5)(B)(i).

⁵³ *Mifeprex Prescriber Agreement Form*, U.S. FOOD & DRUG ADMIN. 1, 1 (Mar. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_03_23_Prescriber_Agreement_Form_for_Danco_Laboratories_LLC.pdf; *Mifepristone Tablets, 200 mg Prescriber Agreement Form*, U.S. FOOD & DRUG ADMIN. 1, 1 (Mar. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_03_23_Prescriber_Agreement_Form_for_GenBioPro_Inc..pdf.

⁵⁴ *Mifeprex Prescribing Information*, *supra* note 14, at 1.

However, telemedical chemical abortions raise concerns for patients living in healthcare deserts without access to adequate medical care. As ACOG’s citizen petition contends, a telemedical chemical abortion “offers a particular benefit for patients living in rural and medically underserved areas where there is no access to in-person abortion care.”⁵⁵ Yet, “[i]t is estimated that over 80% of US counties, or about a third of the US population, have poor access to the services they need for adequate health care,” which includes emergency services.⁵⁶ A separate report identifies “that over 35% of counties are considered maternity care deserts” without “a single birthing facility or obstetric clinician.”⁵⁷ Thus, a patient in a healthcare desert is at risk for not receiving prompt medical attention if she suffers complications. Consequently, the prescriber certification ETASU ensures there is a plan in place for the patient to receive prompt medical or surgical intervention if she suffers complications, even if she lives in a healthcare desert.

ACOG’s citizen petition argues that the prescriber certification ETASU “chill[s] a health care provider’s decision to offer this medication” because of the “possibility of a data breach” and their “fear [of] anti-abortion threats and violence if their registrations became public.”⁵⁸ Essentially, the citizen petition asks the FDA to remove the prescriber certification based upon a third-party private actor’s possible tortious or illegal actions, *i.e.*, breaching the data and/or harassing the abortion providers. However, both federal and state law provide criminal and civil remedies for various situations of alleged harassment or data breaches against abortion providers.⁵⁹ For example, the Freedom of Access to Clinic Entrances (“FACE”) Act provides civil remedies and criminalizes actions using “force or threat of force” or “attempts to injure, intimidate or interfere with any person” because a person is, has been, or is intimidated from “obtaining or providing reproductive health services.”⁶⁰ Accordingly, the FACE Act and other federal and state laws provide remedies for alleged data breaches and harassment against abortion providers. Thus, we urge the FDA to keep the prescriber certification ETASU as a patient safeguard.

⁵⁵ American College of Obstetricians and Gynecologists Citizen Petition, *supra* note 5, at 9.

⁵⁶ Jacqueline Ross, *The Impact of Health Care Deserts on Patient Safety*, 39 J. PERIANESTHESIA NURSING 686, 686 (2024).

⁵⁷ *Nowhere to Go: Maternity Care Deserts Across the US 2024 Report*, MARCH OF DIMES 1, 3 (2024), https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf.

⁵⁸ American College of Obstetricians and Gynecologists Citizen Petition, *supra* note 5, at 14–15.

⁵⁹ *See, e.g.*, *Planned Parenthood Fed’n of Am. v. Newman*, 51 F.4th 1125, 1130 (9th Cir. 2022) (including claims of “trespass, fraud, conspiracy, breach of contracts, unlawful and fraudulent business practices, violating civil RICO, and violating various federal and state wiretapping laws” for undercover journalism activities against an abortion provider).

⁶⁰ 18 U.S.C. § 248(a)(1).

B. The Pharmacy Certification ETASU Prevents Patients from Receiving Unapproved and Misbranded Chemical Abortion Drugs.

The pharmacy certification form supports patient safety by ensuring patients receive chemical abortion drugs from medically reliable sources. ACOG’s petition claims that “there is no valid reason for maintaining Prescriber Certification, undermining any justification for this derivative ETASU [the Pharmacy Certification].”⁶¹ The petition further claims that the Pharmacy Certification ETASU will result in “additional burdens and delay.”⁶² However, as discussed throughout this comment, mifepristone is a dangerous drug that requires ETASU in order to ensure patient safety. Specifically, the Pharmacy Certification ETASU protects patients from drug trafficking, *i.e.*, receiving unapproved and misbranded chemical abortion drugs from unscrupulous online websites. Protecting pregnant women and adolescents from non-FDA approved chemical abortion drugs, which only exacerbate health and safety risks, is a valid reason for ensuring retail pharmacies are certified before they dispense mifepristone and misoprostol.

The FDA has warned the public about the unauthorized selling of mifepristone through websites such as Aid Access and Rablon, and has sent warning letters to these organizations about their unlawful activity.⁶³ In fact, the FDA notes, “[t]here have also been several criminal cases related to the online sale of mifepristone for medical termination of pregnancy.”⁶⁴ The online distribution of these drugs through non-certified pharmacies is not only illegal, it also raises patient safety concerns because the FDA cannot ensure the safety or efficacy of unapproved or misbranded drugs.

Ensuring the drugs are distributed through certified pharmacies is also critical because the United States is experiencing interstate abortion drug trafficking. Specifically, some states protect women and preborn children by banning abortion, but despite these pro-life laws, there is an unlawful shipment of chemical abortion drugs into those states. A recent example of this occurred in Texas where the state brought a suit against Dr. Margaret Daley Carpenter, who was licensed in New York, but provided abortion-inducing drugs to a Texan through telehealth despite not being a licensed Texas physician nor authorized to practice telemedicine in Texas.⁶⁵ The district court entered final judgment and an injunction against Dr. Carpenter, holding that she violated the Texas Medical Practice Act “by practicing medicine

⁶¹ American College of Obstetricians and Gynecologists Citizen Petition, *supra* note 5, at 15.

⁶² *Id.* at 17.

⁶³ *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, *supra* note 6.

⁶⁴ *Id.*

⁶⁵ Petition & Application for Temporary & Permanent Injunctive Relief at 1, *Texas v. Carpenter*, No. 471-08943-2024 (Tex. Dist. Ct. Feb. 13, 2025).

without a license and registration in the State of Texas” and violated the state’s law protecting preborn children from abortion violence.⁶⁶ Notably, the state claimed that Dr. Carpenter admitted through an online biography that she worked with Aid Access in 2020—an organization that the FDA has acknowledged is violating the law by providing unapproved and misbranded chemical abortion drugs, as discussed above⁶⁷—“and continues to work with [the] organization[.]”⁶⁸ Thus, the interstate trafficking of abortion drugs poses health and safety concerns for patients, but the pharmacy agreement form helps safeguard patients against unapproved and misbranded drugs.

Ultimately, the FDA needs to ensure that medically reliable sources are dispensing chemical abortion drugs, which necessitates the Pharmacy Certification ETASU. The FDA cannot ensure the safety or efficacy of drugs if the agency does not know where the drugs are coming from. Thus, the Pharmacy Certification ETASU is an extra layer of protection for pregnant women and adolescents and should remain in place.

C. The Patient Agreement ETASU Protects the Informed Consent and Health of Patients.

The patient agreement form provides an extra layer of informed consent protection for women seeking a chemical abortion. Heightened abortion-related informed consent laws are common in the United States.⁶⁹ In fact, at the time of the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*, a majority of states had some type of abortion-related informed consent law.⁷⁰ Even under *Roe*’s purported right to abortion, the Supreme Court recognized “that as with any medical procedure, the State may require a woman to give her written informed consent to an abortion,” and upheld a law requiring “provision of specific information by the doctor and the mandatory 24-hour waiting period” in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁷¹

The patient agreement ETASU ensures a patient recognizes when she needs to contact her healthcare provider for possible emergency care for her complications.⁷²

⁶⁶ *Texas v. Carpenter*, No. 471-08943-2024, slip op. at 1 (Tex. Dist. Ct. Feb. 13, 2025).

⁶⁷ *Warning Letter: Aidaccess.org*, FDA (Mar. 12, 2019), <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019>.

⁶⁸ Petition & Application for Temporary & Permanent Injunctive Relief, *supra* note 65, at 4.

⁶⁹ Clarke D. Forsythe & Carolyn McDonnell, *The States’ Response to Dobbs v. Jackson Women’s Health Organization*, 39 NOTRE DAME J.L. ETHICS & PUB. POL’Y 171, 195 (2025).

⁷⁰ *See id.*

⁷¹ 505 U.S. 833, 881 (1992) (plurality opinion), *overruled by Dobbs*, 597 U.S. 215.

⁷² *Mifeprex Patient Agreement Form*, U.S. FOOD & DRUG ADMIN. 1, 1 (Jan. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_01_03_Patient_Agreement_Form.pdf; *Mifepristone Tablets, 200mg Patient Agreement Form*, U.S. FOOD & DRUG ADMIN. 1, 1 (Jan.

Abortion prescribers employ a “commonly used analogy” that the pain of a chemical abortion is similar to “period pain,”⁷³ but “some [patients] found comparisons to period pain inaccurate and misleading,” and likewise “[m]any felt unprepared for pain.”⁷⁴ The reality is that a chemical abortion “takes much longer, involves far more bleeding and pain, and complications occur four times more frequently from medical as compared to surgical abortions.”⁷⁵ The patient needs to recognize when the bleeding might be a sign of an incomplete abortion, or an “undiagnosed ectopic pregnancy because some of the expected symptoms experienced with a medical abortion (abdominal pain, uterine bleeding) may be similar to those of a ruptured ectopic pregnancy.”⁷⁶ The patient agreement form makes sure the patient knows who to contact if she cannot reach her provider.⁷⁷ This is critical because the patient might need “prompt medical or surgical intervention” for certain complications,⁷⁸ but she first has to know when she must reach out to a healthcare provider and who she should contact about possible complications. Accordingly, the patient agreement ETASU is a critical safeguard for patient safety.

In sum, we urge the FDA to retain the current ETASU—prescriber certification, pharmacy certification, and patient agreement form—to safeguard the health and informed consent of patients.

III. The 2021 Non-Enforcement Decision and 2023 Removal of the In-Person Dispensing Requirement Are Not in Accordance with Federal Law’s Restrictions on Mailing Abortion Matter.

By removing the in-person dispensing requirement, the FDA permitted the distribution of mifepristone through mail or common carrier, which is not in accordance with federal law.⁷⁹ 18 U.S.C. §§ 1461–1462, which are popularly known as the Comstock Act, contain mail-order abortion rules that prohibit mailing or shipping abortifacient matter.

2023),

https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_01_03_Patient_Agreement_Form.pdf.

⁷³ Hannah McCulloch et al., *Expectations and experiences of pain during medical abortion at home: a secondary, mixed-methods analysis of a patient survey in England and Wales*, 51 *BMJ SEXUAL & REPROD. HEALTH* 137, 137 (2025).

⁷⁴ *Id.* at 142.

⁷⁵ RSCH. COMM., AM. ASS’N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, MEDICATION ABORTION, *supra* note 8, at 3.

⁷⁶ *Mifeprex Prescribing Information*, *supra* note 14, at 6.

⁷⁷ *Mifeprex Patient Agreement Form*, *supra* note 72, at 1; *Mifepristone Tablets, 200mg Patient Agreement Form*, *supra* note 72, at 1.

⁷⁸ *Mifeprex Prescribing Information*, *supra* note 14, at 1.

⁷⁹ See 5 U.S.C. § 706(2)(A) (“The reviewing court shall . . . hold unlawful and set aside agency action . . . found to be . . . not in accordance with law.”).

18 U.S.C. § 1461 prohibits mailing abortifacient matter through the United States Postal Service (“USPS”). Under Section 1461:

Every article or thing designed, adapted, or intended for producing abortion . . . ; and [e]very article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for producing abortion . . . [i]s declared to be nonmailable matter and shall not be conveyed in the mails or delivered from any post office or by any letter carrier. Whoever knowingly uses the mails for the mailing, carriage in the mails, or delivery of anything declared by this section or section 3001(e) of title 39 [regarding nonmailable matter] to be nonmailable, or knowingly causes to be delivered by mail according to the direction thereon, or at the place at which it is directed to be delivered by the person to whom it is addressed, or knowingly takes any such thing from the mails for the purpose of circulating or disposing thereof, or of aiding in the circulation or disposition thereof, shall be [subject to criminal penalties].

Congress used its postal power to pass Section 1461.⁸⁰ Notably, in reviewing other provisions of Section 1461, the Supreme Court upheld the statute in *Roth v. United States*, determining that “the federal obscenity statute punishing the use of the mails for obscene material is a proper exercise of the postal power delegated to Congress by Art. I, § 8, cl. 7.”⁸¹ The Supreme Court later affirmed “that 18 U.S.C. § 1461, ‘applied according to the proper standard for judging obscenity [*i.e.*, *Miller* test], do[es] not offend constitutional safeguards against convictions based upon protected material, or fail to give men in acting adequate notice of what is prohibited.”⁸²

18 U.S.C. § 1462 proscribes shipping abortifacient matter through a common carrier or interactive computer service. Section 1462 reads:

Whoever brings into the United States, or any place subject to the jurisdiction thereof, or knowingly uses any express company or other common carrier or interactive computer service . . . for carriage in interstate or foreign commerce . . . any drug, medicine, article, or thing designed, adapted, or intended for producing abortion . . . ; or [w]hoever knowingly takes or receives, from such express company or other common carrier or interactive computer service . . . any matter or thing the carriage or importation of which is herein made unlawful.

⁸⁰ McDonnell, *supra* note 4, at 107.

⁸¹ 354 U.S. 476, 493 (1957).

⁸² *Hamling v. United States*, 418 U.S. 87, 99 (1974) (second alteration in original) (quoting *Roth*, 354 U.S. at 492); *see Miller v. California*, 413 U.S. 15 (1973).

Congress used its commerce power to pass Section 1462.⁸³ Here, Congress is regulating the “instrumentalities of interstate commerce, or persons or things in interstate commerce.”⁸⁴ Accordingly, Congress is regulating the “express company or other common carrier or interactive computer service” as instrumentalities and the abortifacients as “things” in interstate commerce. The Supreme Court upheld Section 1462 when reviewing separate provisions in the context of obscenity in *United States v. Orito*, especially because of the “legislatively determined risk of ultimate exposure . . . to the public and the harm that exposure could cause.”⁸⁵

Federal law separately “direct[s] federal officers to adhere to the prohibition on mailing abortifacients” in 18 U.S.C. § 552.⁸⁶ The statute applies to “[w]hoever, being an officer, agent, or employee of the United States, knowingly aids or abets any person engaged in any violation of any of the provisions of law prohibiting importing . . . or sending or receiving by mail . . . means for procuring abortion.”⁸⁷ 18 U.S.C. § 552 “traces back to the Comstock Act of 1873, but Congress last amended and affirmed this law in 1994.”⁸⁸

Media and a litigant in *Food & Drug Administration v. Alliance for Hippocratic Medicine*⁸⁹ have raised a desuetude argument about the mail-order abortion rules, “contend[ing] that [the] law’s nonuse or obsolescence effectively repeals it.”⁹⁰ However, desuetude is a disfavored legal doctrine because “[a] statute is not repealed by nonuse or desuetude. . . . The bright-line rule is that a statute has effect until it is repealed.”⁹¹ This canon of statutory construction stems from how “only the legislature has the power both to enact and to disenact statutes.”⁹²

It is true that Congress passed the original “Comstock Act”—the predecessor to 18 U.S.C. § 1461—in 1873. However, Congress “amended or (re)codified the law ten times” since then, most recently in 1994.⁹³ Likewise, the predecessor to 18 U.S.C. § 1462 originated in 1897, but “Congress subsequently amended or (re)codified the law nine times.”⁹⁴ Congress most recently amended Section 1462 in 1996 during the

⁸³ McDonnell, *supra* note 4, at 109.

⁸⁴ *United States v. Lopez*, 514 U.S. 549, 558 (1995) (citations omitted).

⁸⁵ 413 U.S. 139, 143–44 (1973).

⁸⁶ McDonnell, *supra* note 4, at 110.

⁸⁷ 18 U.S.C. § 552.

⁸⁸ McDonnell, *supra* note 4, at 110.

⁸⁹ *Id.* at 126 (citing Transcript of Oral Argument at 49, *FDA*, 602 U.S. 367 (No. 23-235)).

⁹⁰ *Id.*

⁹¹ ANTONIN SCALIA & BRYAN A. GARNER, *READING LAW: THE INTERPRETATION OF LEGAL TEXTS* 336 (2012).

⁹² *Id.* at 339.

⁹³ McDonnell, *supra* note 4, at 127–28; *see id.* at 133–39.

⁹⁴ *Id.* at 128; *see id.* at 139–144

Clinton Administration, when it expanded the statute to encompass prohibited matter sent through an “interactive computer service.”⁹⁵

Thus, the Comstock Act’s mail-order abortion rules prohibit the mailing or shipping of abortifacient matter. The FDA should reestablish an in-person dispensing requirement for chemical abortion drugs so that distribution of these drugs is in accordance with federal law.

IV. The FDA Should Reestablish Prior Safeguards that Mandated Adverse Event Reporting and Required In-Person Dispensing.

The FDA should restore critical safeguards for patient safety: adverse event reporting for non-fatalities and in-person dispensing of chemical abortion drugs. Adverse event reporting gives the FDA data to review drug complications and safety, which support better health outcomes for patients. In-person dispensing provides an opportunity for more effective screening of intimate partner violence, which reduces the risk of coerced abortion.⁹⁶ We urge the FDA to restore these safeguards.

A. *Adverse Event Reporting Ensures the FDA Has the Proper Data to Monitor Drug Complications and Ensure Patient Safety.*

The FDA should restore adverse event reporting for non-fatal adverse events, not just fatalities, because reliable public health data on abortion, including abortion complication data, ensure better patient outcomes. Likewise, chemical abortion is an elective procedure, requiring the highest level of informed consent, and a woman cannot give fully informed consent without accurate public health data. Prior to 2016, the FDA required adverse event reporting for both fatal and non-fatal adverse events. In 2016, the “FDA reasoned that non-fatal adverse events did not have to be recorded because the risks associated with mifepristone were well known.”⁹⁷ This action was arbitrary and capricious under the Administrative Procedure Act (“APA”).

Under the APA, federal courts are required to “hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”⁹⁸ Accordingly, “the agency must examine the relevant data and articulate a satisfactory explanation for its action including a ‘rational connection between the facts found and the choice made.’”⁹⁹ “An agency violates these rules where it ‘entirely fail[s] to consider an important aspect

⁹⁵ *Id.* at 128.

⁹⁶ See Calum Miller, *Online Mail-Order Chemical Abortion: A Threat to Abuse and Trafficking Victims*, CHARLOTTE LOZIER INST. (July 18, 2023), <https://lozierinstitute.org/online-mail-order-chemical-abortion-a-threat-to-abuse-and-trafficking-victims/>.

⁹⁷ *All. for Hippocratic Med.*, 78 F.4th at 246.

⁹⁸ 5 U.S.C. § 706(2)(A).

⁹⁹ *Moter Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1993) (citing *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)).

of the problem,’ or offers ‘an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.’”¹⁰⁰ Here, in 2016, the FDA did not consider how altering the safeguards on mifepristone would change the risk profile of the chemical abortion drug regimen.¹⁰¹

Removing non-fatal adverse event reporting also reduced public health data. The FDA Adverse Event Reporting System (“FAERS”) provides insufficient data for evaluating the safety of mifepristone.¹⁰² It is virtually certain that the FDA’s data is incomplete.¹⁰³ “Common estimates of the proportion of adverse events actually captured by FDA in AERS are from one to ten percent.”¹⁰⁴ Even with its limitations, the FAERS has shown that women have experienced significant complications after taking mifepristone. For example, the FAERS Mifeprex reports through December 31, 2024 documented 36 deaths, 4,252 adverse events, 1,056 hospitalizations (excluding deaths), 606 blood loss incidents requiring transfusions, 422 infections, and 79 severe infections.¹⁰⁵

Despite mifepristone’s known risks, the FDA eliminated the requirement for providers to report non-fatal adverse events in 2016, making non-fatal adverse event reporting voluntary. This stripped the agency of its ability to effectively monitor complications going forward and further limited U.S. data on chemical abortion drugs. The serious limitations of U.S. abortion data have been documented.¹⁰⁶ The U.S. public health system does not require by law the collection and reporting of abortion data and does not thoroughly or reliably track abortions or abortion complications.¹⁰⁷

If the FDA does not require or maintain reliable data, there is reason to doubt the reliability of the existing data on mifepristone’s risks and complications. These data limitations hinder women from providing full informed consent because medical professionals do not have, and cannot provide, an accurate picture of the risks of

¹⁰⁰ *All. for Hippocratic Med.*, 78 F.4th at 245 (citing *Moter Vehicle Mfrs. Ass’n*, 463 U.S. at 43) (alteration in original).

¹⁰¹ *See id.* at 246–47.

¹⁰² Christina A. Circucci et al., *Mifepristone Adverse Events Identified by Planned Parenthood in 2009 and 2010 Compared to Those in the FDA Adverse Event Reporting System and Those Obtained Through the Freedom of Information Act*, HEALTH SERVS. RSCH. & MANAGERIAL EPIDEMIOLOGY, Dec. 21, 2021, at 1, 4 (“FAERS is inadequate to evaluate the safety of mifepristone” due to reporting discrepancies, and the fact that the FDA no longer mandates reporting of non-lethal adverse events.).

¹⁰³ STAFF OF SUBCOMM. ON CRIM. JUST., *supra* note 23, at 27.

¹⁰⁴ *Id.*

¹⁰⁵ *Mifepristone U.S. Post-Marketing Adverse Events Summary Through 12/31/2024*, U.S. FOOD & DRUG ADMIN. 1, 1–2 (Dec. 31, 2024), <https://www.fda.gov/media/185245/download>.

¹⁰⁶ *See, e.g., John M. Thorp et al., Long-term Physical and Psychological Health Consequences of Induced Abortion: A Review of the Evidence*, 58 OBSTETRICS & GYNECOLOGY SURV. 67 (2003).

¹⁰⁷ *See Abortion Surveillance Findings and Reports*, CDC (Nov. 27, 2024), <https://www.cdc.gov/reproductive-health/data-statistics/abortion-surveillance-findings-reports.html>.

mifepristone. Likewise, insufficient public health data impair medical professionals in their treatment of patients suffering chemical abortion complications in the short-term, as well as their long-term care of post-abortive women.¹⁰⁸

Ultimately, public health data provide better patient outcomes because it helps educate providers and the public on the risks of dangerous drugs like mifepristone. It highlights areas that need improvement in patient care and safety. If medical professionals have reliable data on chemical abortion complications, they can better treat patients experiencing complications or work towards avoiding such adverse events to the extent possible.

It is, and should be, the FDA's goal to have the most accurate data in order to ensure the safety and efficacy of any drug it approves, especially one as dangerous as mifepristone. Requiring comprehensive adverse event reporting is how the FDA can accomplish this goal. Without it, women and adolescent girls will continue to suffer significant complications that may even lead to their deaths. Accordingly, the FDA should reinstate the non-lethal adverse event reporting requirement.

B. In-Person Dispensing Improves Screening of Intimate Partner Violence and Decreases the Risk of Coerced Abortions.

In-person dispensing of mifepristone facilitates screening pregnant women and adolescents for domestic violence and coerced abortions.¹⁰⁹ Yet, ACOG's petition claims that "telehealth protocols for medication abortion offer the same patient protections as in-person dispensing and provide an equivalent level of patient care."¹¹⁰ This claim contradicts how telehealth greatly impairs medical professionals' ability to screen for coercion and domestic violence. At its core, telemedicine separates women and adolescent patients from their medical professional. As a result, women are isolated and more susceptible to coercion from numerous sources, including trafficking, partners, or other family members.

Coerced abortion is a significant problem. In a 2023 study published in *Cureus* medical journal, researchers found that over 60% of women who had abortions reported experiencing high levels of pressure to abort from one or more sources.¹¹¹ These women also reported having higher levels of mental health issues after having

¹⁰⁸ See Brief *Amicus Curiae* of Americans United for Life in Support of Respondents and Affirmance, *FDA*, 602 U.S. 367 (No. 23-235).

¹⁰⁹ The removal of the in-person dispensing requirement also raised a legal issue of whether the action was arbitrary and capricious. In 2021, the FDA relied upon FAERS data to show that the distribution of mifepristone was safe following the 2016 removal of safeguards, even though the FDA no longer required non-fatal adverse event reporting following the 2016 changes. See *All. for Hippocratic Med.*, 78 F.4th at 249.

¹¹⁰ American College of Obstetricians and Gynecologists Citizen Petition, *supra* note 5, at 6.

¹¹¹ David C. Reardon & Tessa Longbons, *Effects of Pressure to Abort on Women's Emotional Responses and Mental Health*, CUREUS, Jan. 31, 2023, at 1, 1.

an abortion.¹¹² Similarly, another study found that a large percentage of women identified their abortion as either accepted but inconsistent with their values and preferences (43%), or unwanted or coerced (24%)¹¹³ Only 33% of women in the study said their abortion was wanted.¹¹⁴

Coerced abortion is closely tied to intimate partner violence (“IPV”). There are “[h]igh rates of physical, sexual, and emotional IPV . . . among women seeking a[n] abortion].”¹¹⁵ As reported by ACOG, for women seeking abortion, the prevalence of IPV is nearly three times greater than women continuing a pregnancy.¹¹⁶ Post-abortion IPV victims also have a “significant association” with “psychosocial problems including depression . . . , suicidal ideation . . . , stress . . . , and disturbing thoughts.”¹¹⁷ Coerced abortion is so prevalent that numerous states have passed legislation to address the problem, including outright prohibitions of coerced abortion or including warnings to women as part of informed consent requirements.¹¹⁸

Due to the growing rise in coerced abortions, medical professionals must “[s]creen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.”¹¹⁹ Yet, telemedicine cannot ensure that a coercive partner, friend, family member, or caregiver is not in the room with a woman seeking a chemical abortion. ACOG also recommends that IPV screening should occur periodically and “at various times . . . because some women do not disclose abuse the first time they are asked.”¹²⁰ Thus, telehealth ineffectively screens women seeking chemical abortions for domestic violence or coercion. If a woman changes her mind, no medical professional is there to help her. She is left alone to care for her physiological and psychological health, as well as her safety if complications or IPV arise.

Accordingly, the FDA should reinstate the in-person dispensing requirement, which is a critical safeguard in helping to screen for coerced abortion and ensuring women’s authentic choice.

¹¹² *Id.*

¹¹³ David C. Reardon et al., *The Effects of Abortion Decision Rightness and Decision Type on Women’s Satisfaction and Mental Health*, CUREUS, May 11, 2023, at 1, 1.

¹¹⁴ *Id.*

¹¹⁵ Hall, *supra* note 49, at 15.

¹¹⁶ COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, REPRODUCTIVE AND SEXUAL COERCION, COMM. OP. NO. 554, at 2 (reaffirmed 2025).

¹¹⁷ Hall, *supra* note 49, at 11.

¹¹⁸ 25 states currently have some form of law to protect women from coerced abortion. Forsythe, *The States’ Response to Dobbs*, *supra* note 69, at 194 (listing statutes).

¹¹⁹ COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, INTIMATE PARTNER VIOLENCE, *supra* note 49, at 3.

¹²⁰ *Id.*

V. The FDA Should Implement an Ultrasound Safeguard to Confirm the Gestational Age and Rule Out Ectopic Pregnancy Before the Prescription of Mifepristone.

To ensure the safety and efficacy of mifepristone, the FDA should implement an ultrasound requirement prior to the prescription of mifepristone. The FDA has never required medical professionals to perform an ultrasound on the patient prior to prescribing mifepristone. Yet, in approving chemical abortion drugs, the FDA relied on studies that “purported to show that mifepristone was effective in the majority of cases, under the conditions imposed in each study.”¹²¹ One of those conditions included “an ultrasound to verify gestational age and diagnose ectopic pregnancies.”¹²² However, the FDA did not include an ultrasound as a condition of use when it approved mifepristone. Likewise, in 2016, the FDA did not institute an ultrasound requirement when it removed additional safeguards, even though the FDA removed those safeguards based upon a study that included an ultrasound as a condition of the study.¹²³ In other words, mifepristone’s conditions of use did not mirror those within the studies that purported to show the drug’s safety and efficacy during the 2000 approval or 2016 deregulation.

Congress placed safeguards within the Food, Drug, and Cosmetic Act (“FDCA”) to ensure new drugs are safe and efficacious for patients.¹²⁴ A new drug application must meet patient safeguards, but fails to do so when:

the investigations . . . do not include adequate tests . . . to show whether or not such drug is safe for use under the conditions prescribed, recommended, or suggested in the proposed labeling; . . . [there is] insufficient information to determine whether such drug is safe for use under such conditions; or . . . there is a lack of substantial evidence that the drug will have the effect it purports or is represented to have under the conditions of use prescribed, recommended, or suggested in the proposed labeling thereof.¹²⁵

If the application does not meet these patient health and safety standards, the FDA Secretary “shall issue an order refusing to approve the application.”¹²⁶ Accordingly, the FDA’s failure to include an ultrasound requirement—even though an ultrasound was a condition of the studies the FDA relied upon in the 2000 approval and 2016

¹²¹ *All. for Hippocratic Med.*, 78 F.4th at 224.

¹²² *Id.*

¹²³ Compl., *supra* note 35, at ¶ 203 (citing Beverly Winikoff et al., *Extending Outpatient Medical Abortion Services Through 70 Days of Gestational Age*, 120 OBSTETRICS & GYNECOLOGY 1070 (2012)).

¹²⁴ 21 U.S.C. § 355.

¹²⁵ 21 U.S.C. § 355(d).

¹²⁶ *Id.*

changes—was not in accordance with the FDCA and was arbitrary and capricious under the APA.¹²⁷

The FDA’s failure to include an ultrasound safeguard increased medical risks for women undergoing a chemical abortion, especially those with ectopic pregnancies. Ultrasound is the only reliable method of ruling out an ectopic pregnancy in pregnant patients, which means a medical professional cannot determine via telemedicine whether a pregnancy is ectopic.¹²⁸ This exacerbates the medical risks of a chemical abortion, especially after the FDA’s removal of the in-person dispensing requirement, because a ruptured ectopic pregnancy mimics the “symptoms experienced with a medical abortion (abdominal pain, uterine bleeding).”¹²⁹

If a woman is diagnosed with an ectopic pregnancy by ultrasound prior to rupture, there are non-invasive treatments like methotrexate, which may resolve the ectopic pregnancy without surgery.¹³⁰ Even if surgery is required to resolve the ectopic pregnancy, it is much more likely to be able to save a woman’s fallopian tube if the surgery is done under non-emergency circumstances.¹³¹

However, if the diagnosis of ectopic pregnancy is made after rupture, it is almost impossible to spare her fallopian tube,¹³² and she will lose that organ and may have trouble becoming pregnant in the future.¹³³ This damage is completely unnecessary and could be prevented by a simple in-person visit and ultrasound. The FDA is well aware of this reality, which is why the mifepristone label lists “[c]onfirmed/suspected ectopic pregnancy” as a contraindication, and warns “[e]ctopic pregnancy: [e]xclude before treatment.”¹³⁴ As recently as its “Mifepristone US Post-Marketing Adverse Events Summary through 12/31/2024,” the FDA affirmed that “[a]dministration of mifepristone and misoprostol is contraindicated in patients with confirmed or suspected ectopic pregnancy (a pregnancy outside the uterus),”¹³⁵ Regardless, the FDA has never required an ultrasound before a mifepristone

¹²⁷ See 5 U.S.C. § 706(2)(A).

¹²⁸ *Ectopic Pregnancy*, MAYO CLINIC (Mar. 12, 2022), <https://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/diagnosis-treatment/drc-20372093>.

¹²⁹ *Mifeprex Prescribing Information*, *supra* note 14, at 6.

¹³⁰ RSCH. COMM., AM. ASS’N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, ECTOPIC PREGNANCY, PRAC. GUIDELINE NO. 9, at 2–3 (2020).

¹³¹ See Elsa S. Vadekekut & David M. Gnugnoli, *Ectopic Pregnancy*, STATPEARLS PUBL’G (Mar. 27, 2025), <https://www.ncbi.nlm.nih.gov/books/NBK539860/> (discussing treatment for ectopic pregnancies in emergency and non-emergency situations); see also *Ectopic Pregnancy*, *supra* note 128 (same).

¹³² See *Ectopic Pregnancy*, *supra* note 128 (“Typically . . . a ruptured tube must be removed.”).

¹³³ See Vadekekut, *supra* note 131 (noting that a woman’s fertility may be impacted in cases where there is “tubal rupture, resulting in life-threatening hemorrhage and hemodynamic instability”).

¹³⁴ *Mifeprex Prescribing Information*, *supra* note 14, at 1.

¹³⁵ *Mifepristone U.S. Post-Marketing Adverse Events Summary Through 12/31/2024*, *supra* note 105, at 1.

prescription, which is *the only reliable tool* to diagnose or rule out an ectopic pregnancy.

Ultrasound is also the most accurate method to establish or confirm gestational age in the first trimester.¹³⁶ Dating a pregnancy by using a woman's last menstrual period ("LMP") is far less accurate. ACOG indicates only one half of women accurately recall their LMP.¹³⁷ In one study, forty percent of women had more than a five-day discrepancy between their LMP dating and the ultrasound dating.¹³⁸ In this regard, LMP dating is not nearly as precise as an ultrasound. But an accurate measurement of gestational age is required to show that a woman is even a candidate for a chemical abortion.

In sum, because ultrasounds are the most accurate way to rule out ectopic pregnancies and confirm gestational age, the FDA should implement an ultrasound requirement to safeguard the welfare of women and adolescents taking mifepristone.

VI. Conclusion.

For the foregoing reasons, the FDA should deny ACOG's citizen petition. We urge the FDA to reinstate prior safeguards requiring in-person dispensing and mandating adverse event reporting, as well as establish a new ultrasound safeguard. These safeguards will protect patient safety and ensure that chemical abortion drug distribution is consistent with federal law's restrictions on mailing or shipping abortifacient matter.

Sincerely,

Carolyn McDonnell, Esq.
Litigation Counsel
AMERICANS UNITED FOR LIFE

Danielle Pimentel, Esq.
Policy Counsel
AMERICANS UNITED FOR LIFE

¹³⁶ COMM. ON OBSTETRIC PRACTICE, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS ET AL., METHODS FOR ESTIMATING THE DUE DATE, COMM. OP. NO. 700, at 1 (reaffirmed 2025).

¹³⁷ *Id.* at 2.

¹³⁸ *Id.*